CHECKLIST FOR THE INITIAL APPROVAL OF AN INSURED PREFERRED PROVIDER PLAN
Pursuant to the Requirements of M.G.L. c. 176I and 211 CMR 51.00
(When submitting an initial application for an Insured Preferred Provider Plan, please also submit the appropriate Managed Care Checklists.)

NOTE TO COMPANIES COMPLETING THIS CHECKLIST: ***Please include a completed checklist when submitting an application for an insured preferred provider plan indicating, as applicable, the page number(s), and/or section(s), where the required information may be found in the submitted materials. Please indicate if a requirement is not applicable (N/A) and explain the reason(s) why.***

Carrier Name: _____

NAIC #: _____

Contact Name & Title: _____

Address: _____

Telephone: _____

Fax: _____

Email Address: _____

Date Received: _____

Reviewed by: _____

Product Name & Form #: _____

_____

_____

_____

$100 filing fee remitted pursuant to 801 CMR 4.02(28): _____

The following organizations may currently operate insured preferred provider plans according to the provisions of M.G.L. c. 176I and 211 CMR 51.00:

- Companies licensed to write health insurance pursuant to M.G.L. c. 175;
- Fraternal Benefit Societies licensed to write health insurance pursuant to M.G.L. c. 176;
- Non-Profit Hospital Service Corporations organized under M.G.L. c. 176A;
- Medical Service Corporations organized under M.G.L. c. 176B;
- Dental Service Corporations organized under M.G.L. c. 176E;
- Optometric Service Corporations organized under M.G.L. c. 176F; and
- Health Maintenance Organizations licensed to write health insurance pursuant to M.G.L. 176G.

Definitions from M.G.L. c. 176I, § 1 and 211 CMR 51.03 (if used)

_____ Emergency Medical Condition, "a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of the covered person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B)."

_____ Preferred Provider, "a health care provider, group of health care providers or a network of providers who have contracted with an organization to provide specified covered services in the context of a preferred provider arrangement."

_____ Preferred Provider Arrangement ("PPA"), " a contract between or on behalf of an organization and a preferred provider that complies with the requirements of M.G.L. c. 176I and 211 CMR 51.00."

_____ Preferred Provider Plan, "an insured health benefit plan offered by an organization that provides incentives for covered persons to receive health care services from preferred providers in the context of a preferred provider arrangement."

Application Requirements for Approval of a Preferred Provider Plan as outlined in 211 CMR 51.04(1)

According to 211 CMR 51.04(1), "[a]ny organization seeking approval of a preferred provider plan must submit an application in a format specified by the Commissioner that includes at least the following:

_____ (a) A narrative description of the preferred provider plan to be offered;

_____ (b) A description of the geographical area in which the preferred provider plan is to be offered, including a map of the area with the locations of all preferred providers;

_____ (c) A description of the manner in which covered health care services and other benefits may be obtained by persons using the preferred provider plan, including any requirement that covered persons select a gatekeeper provider;

(d) Provider contracts and contracting criteria;

_____ 1. A narrative description of the financial arrangements between the organization and contracting health care providers, identifying any assumption by the providers of financial risk through arrangements such as per diems, diagnosis-related groups, capitation or percentage withholding of fees;

_____ 2. A copy of every standard form contract with physicians and other health care providers that will be part of the preferred provider plan, including providers included in the plan via leasing, subcontracting, or other arrangements whereby the organization does not contract directly with the providers (do not include rates of payment to providers);

_____ 3. A copy of every standard form contract for all preferred provider arrangements including administrative service agreements;

_____ 4. A copy of the terms and conditions that must be met or agreed to by health care providers desiring to enter into the preferred provider arrangement(s) that will be part of the preferred provider plan (do not include rates of payments to health care providers); and

_____ 5. A description of the criteria and method used to select preferred providers.

_____ (e) A detailed description of the utilization review program;

_____ (f) A detailed description of the quality assurance program;

(g) Benefits and services.

_____ 1. A copy of every standard form evidence of coverage for every preferred provider plan;

_____ 2. A description of any provision for covered services to be payable at the preferred level until an adequate network has been established for a particular service or provider type;

_____ 3. A description of all mandated benefits and provider types available at the preferred and non-preferred level;

_____ 4. A description of the incentives for covered persons to use the services of preferred providers;

_____ 5. A description of any provisions that allow covered persons to obtain covered health care services from a non-preferred provider at the benefit level for the same covered health care service rendered by a preferred provider;

_____ 6. A description of the grievance system available to covered persons, including procedures for the registration and resolution of grievances;

_____ 7. A copy of every standard form contract between the organization and health care purchasers for the preferred provider plan; and

_____ 8. A description of any provisions within the preferred provider plan for holding covered persons financially harmless for payment denials by, or on behalf of, the organization for improper utilization of covered health care services caused by preferred providers.

(h) Preferred Provider directory.

_____ 1. A copy of the preferred provider directory distributed to covered persons; and

_____ 2. A description of the process for distributing the directory to covered persons.

(i) Financial resources.

_____ 1. A description of the arrangements to be used by the organization to protect covered members from financial liability in the event of financial impairment or insolvency of any preferred provider that assumes financial risk; and

_____ 2. Evidence of a surety bond, reinsurance, or other financial resources adequate to guarantee that the organization's obligations to covered persons will be performed.

(j) Rates.

_____ 1. A description of the organization's methodology for establishing premium rates; and

_____ 2. A copy of the average rates for community-rated accounts, non-credible accounts, or their equivalent in the rating structure used by the organization.

_____ (k) Evidence of compliance with M.G.L. c. 176O and 211 CMR 52.00."

(Refer to appropriate Managed Care Checklists)

According to 211 CMR 51.04(2), "[u]pon receipt of a complete application, the Commissioner will review the submitted material to determine whether all requirements set forth in M.G.L. c. 176I and 211 CMR 51.00 have been met, including the following:

_____ (a) Corporate and organizational structure capable of supporting the benefits offered;

_____ (b) Contractual agreements that adequately protect the interests of members;

_____ (c) Utilization systems ensuring the appropriate and efficient use of health services;

_____ (d) Quality assurance system monitoring the quality of care provided to members;

_____ (e) Clear and logical plan for marketing of the preferred provider plan;

_____ (f) Adequate preferred provider networks to guarantee that all services contracted for will be accessible to members on a preferred basis and in all cases without delays detrimental to the health of members;

_____ (g) Operations capable to administer the preferred provider plan and to maintain financial and utilization data for the preferred provider plan in a form separate or separable from other activities of the organization; and

_____ (h) Sufficient financial reserves to support introduction of a preferred provider plan."

<u>Denial of Application for a Preferred Provider Plan as outlined in 211 CMR 51.04(4)</u>

_____ According to 211 CMR 51.04(4), "[i]f an application is denied or a plan is subsequently disapproved, the Commissioner shall notify the organization in writing, stating the reason(s) for the denial. The organization shall have the right to a hearing within 45 days of its receipt of such notice by filing a written request for hearing within 15 days of its receipt of such notice. Within 30 days after the conclusion of the hearing, the Commissioner shall either grant approval or shall notify the applicant in writing of the denial, stating the reason(s) for the denial. The organization shall have the right to judicial review of the Commissioner's decision in accordance with the provisions of M.G.L. c. 30A, § 14."

<u>Requirements of an Evidence of Coverage as outlined in 211 CMR 51.05</u>

_____ According to 211 CMR 51.05(1), "[t]he evidence of coverage must meet the requirements of M.G.L. c. 176I, M.G.L. c. 176O , 211 CMR 51.00, 211 CMR 52.00."
(Refer to appropriate Managed Care Checklist)

According to 211 CMR 51.05(2), "[t]he evidence of coverage must also include the following in clear and understandable language:

_____ (a) a complete description of the benefit differential between services offered by preferred and non-preferred providers;

_____ (b) Provisions that if a covered person receives emergency care and cannot reasonably reach a preferred provider, payment for such care will be made at the same level and in the same manner as if the covered person had been treated by a preferred provider;

_____ (c) Benefit levels for covered health care services rendered by non-preferred providers must be at least 80% of the benefit levels for the same covered health care services

rendered by preferred providers. Payments made to non-preferred providers shall be a percentage of the provider's fee, up to a usual and customary charge, and not a percentage of the amount paid to preferred providers. The 80% requirement shall be met if the coinsurance percentage for a covered health care service rendered by a non-preferred provider is no more than 20 percentage points greater than the highest coinsurance percentage for the same covered health care services rendered by a preferred provider, excluding reasonable deductibles and copayments; and

_____ (d) A description of all benefits required to be provided by law in accordance with all of the provisions of the organization's enabling or licensing statutes."

Please indicate <u>for each evidence of coverage</u> the page number(s), and/or section(s), where the required information may be found.

<u>Reporting Requirements as outlined in 211 CMR 51.06</u>

_____ According to 211 CMR 51.06(1), "[e]ach organization offering a preferred provider plan shall file with the Commissioner any material changes or additions to the material previously submitted on or before their effective date, including amendments to the evidence of coverage and significant changes to the lists of preferred providers." **Please confirm that the carrier will comply with this requirement.**

_____ According to 211 CMR 51.06(2), "[e]ach organization offering a preferred provider plan shall annually file with the Commissioner, within 120 days of the close of its fiscal year, a report covering its prior fiscal year. The annual report shall include at least the following information in a format specified by the Commissioner:

(a) A summary of the number of covered persons in preferred provider plans;

(b) A summary of the utilization experience of persons covered by preferred provider plans; and

(c) A current provider directory which lists preferred providers by specialty and geographic area."

Please confirm that the carrier will comply with this requirement.